# CHAPTER VII

# UTILIZATION REVIEW AND CONTROL

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## REVIEW AND EVALUATION

Under the provisions of federal regulations in 42 CFR 441, Subpart-G 441.300 - 441.310, DMAS must provide for the continuing review and evaluation of the care and services paid through Medicaid, including review of the utilization of the services of providers and by recipients.

Providers will be required to refund DMAS if they are found to have billed DMAS contrary to policy, failed to maintain records to support their claims, or billed for medically unnecessary services. Due to the provision of poor quality services or of any of the above problems, DMAS may limit, suspend, or terminate the provider's contract with DMAS.

## UTILIZATION REVIEW OF THE AGENCY RECIPIENT RECORD AND HOME VISIT

The purpose of utilization review is to determine if services continue to be needed and the amount and kind of services required. Utilization review is mandated to ensure that the health, safety, and welfare of the recipient are protected and addresses quality of care, appropriateness of care, level of care, and cost-effectiveness. DMAS analysts conduct utilization review of documentation submitted by the provider which shows the recipient's needs and available social supports and via on-site quality assurance reviews of the agency's recipient records, interviews with agency staff, recipients, and the recipient's caregivers conducted in the recipient's home, the agency and via telephone call and written communication.

The DMAS staff person responsible for conducting utilization review/quality assurance is employed in the Community-Based Care Section of the Division of Quality Care Assurance.

Once a year, DMAS will notify the provider agency to submit documentation of the recipient's current status on the Recipient Progress Report. The analyst will communicate to the provider any difficulties observed during this desk audit.

During the on-site review, the analyst will review the original screening package and initial assessment by the provider RN for new recipients and all nursing documentation, Aide Records (DMAS-90), the Agency Plans of Care (DMAS-97A), and the Patient Information form (DMAS-122).

During the review process, the analyst will be available to offer technical assistance and consultation to the provider agency regarding DMAS regulations, policies, and procedures. If questions arise regarding compliance issues, the analyst will provide information and assistance. Any issues which, if uncorrected, might result in termination of the provider contract will be presented to the provider agency in writing.

The following information will be closely monitored during the on-site utilization review process:

- The Aide Record (DMAS-90) must be thoroughly completed. The Aide Record must document the care given and the times of arrival to and departure from the client's home each day the aide renders service. The logs must be signed weekly by the aide, the nurse supervisor and the client. In instances where the client is unable to sign and there is no family member to do so, the reason for the absence of this signature must be thoroughly documented on the DMAS-90. The aides' weekly comments should note significant physical, social and emotional aspects of the clients life that week.

- Nursing notes must be in the recipient's record within five days of the last supervisory visit made to the recipient. Any supervisory visit not documented and present in the recipient's record will be considered as not having been made. Nursing notes must reflect all significant contacts with the recipient and document that the registered nurse has made a supervisory visit (with the aide present at least every other visit) in the recipient's home at least every 30 days following the registered nurse's initial evaluation visit. The registered nurse's initial evaluation visit in the recipient's home must also be documented. The registered nurse's documentation must include the observations of the recipient made during the visits as well as any instruction, supervision, or counseling provided to the aide working with the recipient. The registered nurse's notes must also clearly document that he or she has discussed with the client or significant family member the appropriateness and adequacy of service. Client satisfaction with the services should be documented as well as all requirements for RN supervisor and documentation found in Chapter II of this manual.

- The DMAS-95 or DMAS-113A, DMAS-96, DMAS-97 or DMAS-113B, or DMAS-300 and DMAS-97A must be in the client's record. The current and prior DMAS-122s and DMAS-90s for at least the last six months of services must also be in the client's record.

- The aide's personnel file must verify that she or he meets the minimum qualifications outlined in Chapter II.

- The registered nurse supervisor's personnel file must verify that the registered nurse meets the minimum qualifications outlined in Chapter II of this manual.

At least once a year, the Utilization Review Analyst will visit a sample of clients in the client's home to review the appropriateness, quality, and level of care received. If the Plan of Care is found to be inadequate, the analyst may change hours or level of care. The analyst will evaluate the client's condition, satisfaction with the service, and appropriateness of the current Plan of Care.

## FINANCIAL REVIEW AND VERIFICATION

The purpose of financial review and verification of services is to assure that the provider agency bills only for those services which have been provided and which are covered by the DMAS Personal/Respite Care Program and to assure that the appropriate patient pay amounts, if any, have been applied. Any paid provider agency claims which cannot be verified at the time of utilization review cannot be considered a valid claim for services provided.

The aide's records (DMAS-90) **must** support the number of hours billed to DMAS each month. Only DMAS-90s will be used by the Department of Medical Assistance Services to verify services delivered and billed to DMAS. No other documentation (i.e., time sheets) will be used for verification of services. If services billed to DMAS and paid by DMAS are not documented on the DMAS-90, DMAS will require the provider agency to submit an adjusted invoice for any over-billings to DMAS. (See Chapter VI for billing procedures.)

The utilization review analyst will send a letter of utilization review findings to the provider agency; attached to the letter will be a billing problem form listing over-billed and incorrectly billed patient pay amounts found at the time of utilization review and the corrective action the agency needs to take.

The provider agency should submit an adjustment as indicated within 30 days of the receipt of this form. If an adjustment is not received within 30 days, a reminder will be sent to the provider agency and an additional 30 days will be allowed for adjustment of overpaid funds. If at the end of this period no adjustment has been made, DMAS will initiate a demand letter that requires adjustment of overpaid funds be made within 21 days. Failure to respond to this demand letter will result in DMAS recovery of funds from future provider agency remittances. Referral to the DMAS Post-Payment Review Section may be made.

Pursuant to Section 32.1-325.1 of the Code of Virginia, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment is agreed to by DMAS. When a lump sum cash payment is not made, interest will be added on the declining balance at the statutory rate pursuant to the Code of Virginia, Section 32.1-313.1. Interest will not apply pending appeal.

Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates to the satisfaction of DMAS a financial hardship warranting extended repayment terms.

## EXIT CONFERENCE

Following the analyst's review of the records and home visits, the analyst will meet with the appropriate agency staff to discuss findings from the reviews. **The provider agency must provide appropriate staff (as requested by the analyst) for this meeting.**

The agency will be informed of the number of records reviewed, number of home visits made, recommendations regarding level of care change, recommendations regarding changes in care plans, and any pertinent information regarding documentation, service verification issues, quality of care, or provision of services. The analyst will send a letter to the agency verifying that the review was conducted and describing findings from the review.

The provider agency is expected to utilize the findings of the utilization review analyst to comply with regulations, policies, and procedures in the future. Records that have been reviewed should not be altered to meet the compliance issues.

During the review process, the analyst will be available to offer technical assistance and consultation to the provider agency regarding DMAS regulations, policies, and procedures. If questions arise regarding compliance issues, the analyst will provide information and assistance. Any issues which, if uncorrected, might result in termination of the provider contract will be presented in writing.

## AGENCY ANNUAL REVIEW

Each provider agency is reviewed on an annual basis beginning six (6) months from the contract initiation. During this agency review, the utilization review analyst will monitor the agency's compliance with overall provider participation requirements (see Chapter II). Particular attention is given to the requirements for staff providing services as described in the section titled "Adherence to Provider Contract and Special Participation Conditions" of this chapter. The analysts will need to see the provider's contract, all RN licenses, and certification of all aides who have provided personal care services during the year. The analyst will discuss with the agency administration during this review, the agency's overall status as a Medicaid provider, any areas of concern, technical assistance needs, and the plan for addressing those needs, and any recommendations the analyst may have.

## REQUEST FOR CORRECTIVE ACTION

Repeated failure to comply with DMAS regulations, policies, and procedures will result in a corrective action letter to the agency. A corrective action letter cites to the agency those areas which have been found to be out of compliance and requests that a corrective plan of action be submitted to DMAS within a specified time-period. This plan must address all the areas cited in the corrective action letter with time frames indicated within which corrective action will be taken. The agency will be monitored closely during subsequent utilization reviews. If improvement is not made in areas cited, DMAS may move to terminate the provider agency's contract.

## FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself, or some other person. It includes any act that constitutes fraud under applicable Federal and State law.

Since payment of claims is made from both State and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or State court. DMAS maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

### Provider Fraud

The provider is responsible for reading and adhering to applicable State and federal regulations and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his signature or the signature of his authorized agent on each invoice that all information provided the DMAS Program is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit
Division of Program Compliance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Medicaid Fraud Control Unit
Supreme Court Building
101 North Eighth Street
Richmond, Virginia 23219

## Recipient Fraud

Investigations of allegations of recipient fraud are the responsibility of the Medicaid Recipient Audit Unit Division of Program Compliance of the Department of Medical Assistance Services. Recipient records are available to personnel from that unit for investigative purposes. Referrals should be made to:

Supervisor, Recipient Audit Unit
Division of Program Compliance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219